Washington, DC-Thursday, Congressman Harry Teague wrote the following letter to Colonel James Baunchalk following reports of incorrect and potentially dangerous procedures used in the administration of insulin injections at William Beaumont Army Medical Center.

Congressman Harry Teague is a member of the House Veterans' Affairs Subcommittee on Health, which has jurisdiction over Veterans' healthcare facilities.

February 5, 2009

Colonel James Baunchalk

Commander, William Beaumont Army Medical Center

5005 North Piedras Street

El Paso, TX 79920

Dear Colonel Baunchalk:

As a member of the House Veterans Affairs Subcommittee on Health I write today deeply concerned about reports of incorrect and potentially dangerous procedures used in the administration of insulin injections at William Beaumont Army Medical Center (WBAMC) since August 2007. WBAMC provides medical services to many veterans and members of the United States Armed Forces who live in Southern New Mexico, which I represent in Congress. Our veterans and armed servicemen and women deserve the highest level of medical care. I find what has happened to be unacceptable and I expect you are taking immediate steps to prevent this from ever occurring again.

In order to establish what went wrong, ensure we protect the health and welfare of those who have been affected, and ensure such mistakes are never again repeated, I ask that you provide me with complete answers to the following questions. Because of the urgency of this situation, I ask you respond in writing no later than February 13, 2009.

1. How did this incorrect procedure come to be practiced at WBAMC, and why were employees able to continue practicing this incorrect procedure without being corrected by a supervising medical professional?

2. Are there procedures in place meant to prevent mistakes such as this from being made? If so, were they followed?

3. How and when was the practice of this procedure discovered?

4. Once it was discovered that a procedure that did not reflect the best medical practices was in use at WBAMC, what steps were taken to correct the problem? Is there protocol for situations like this, and was it followed?

5. How many people received an insulin shot using this incorrect procedure, how many reside in New Mexico, and how many are Veterans?

6. According to WBAMC statements, the incorrect procedure put patients at risk of contracting Hepatitis B, Hepatitis C and HIV. What are all the health implications for a patient subjected to this incorrect procedure?

7. Can you positively identify all patients who may have received insulin shots through the incorrect procedure?

8. It is my understanding that this incorrect procedure began in August of 2007. What happens in the event that you do not have up-to-date contact information for patients who may be at risk?

9. If an individual believes he or she may be at risk due to an insulin shot he or she received at WBAMC, what steps should an individual take to determine whether or not they may need medical testing or treatment?

10. I have been informed that roughly 9% of those affected are residents of New Mexico and may live a great distance from WBAMC. What steps are you taking to facilitate testing and further treatment for patients who live far away from WBAMC?

11. What specific step s is WBAMC taking to ensure that this does not happen again?

I would also like to thank you in advance for your responses to my questions. I look forward to working with you to ensure our veterans receive only the highest level of medical care.

Sincerely,

Harry Teague

Member of Congress

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